DATE: _____

CLINICAL AREA: _____

How' You Doin'?? 2003

Medication Safety

Instructions:

- ❑ Test your knowledge by asking yourself and at least 5 of your colleagues the following questions.
- ❑ Indicate in the boxes whether you **answered the question correctly (Y)** or **were not able to answer the question (N).** Your manager or supervisor will be able to provide you with the correct answers.
- ❑ Give yourself and your colleagues a pat on the back for a job well done!!! Then, **send the results to Ginnie Daine by May 2, 2003.**
- ❑ Got questions and you and your staff want to discuss a topic, simply check the box to the left of the topic.

?	Critical Issue	1	2	3	4	5	6
	1. What is a medication error?						
	2. Describe what is done with medication error data in your work area.						
	3. What is an Adverse Drug Reaction (ADR)?						
	4. What do you do if you suspect an adverse drug reaction?						
	5. Why are we worried about security of syringes and needles?						
	6. Who is responsible for medication refrigerator checks?						
	7. What drugs are on the floor stock inventory?						
	8. What are high-alert drugs and how do we minimize their associated risks in the Clinical Center?						
	9. Describe the independent double check process you use to validate the infusion pump settings on your patient's controlled substance infusion.						
	10. You have just replaced your patient's fentanyl patch. Describe how you will dispose of the used patch.						
	11. Describe steps you would take to waste a morphine sulfate solution obtained from the PYXIS.						
	12. When you have a drug-filled syringe, describe the steps you take to ensure you deliver the right drug to the right patient.						
	13. What would you do if you were asked to dispense medication to a patient from a container or package that contained more than one label?						

❑ **We would like to discuss this topic further with someone!! (check box if indicated)**

How' YOU Doin' in 2003?

The Answer Sheet☺

Medication Safety
April 21, 2003

1. What is a medication error?
   - Any preventable event that may cause or lead to inappropriate medication use or patient effect while the medication is in the control of the health care professional, patient or, consumer.
   - Any violation of the "5 Rights," i.e., wrong patient, wrong drug, wrong dose, wrong route, or, wrong time including an omitted dose.
2. Describe what is done with medication error data in your work area.
   - Medication errors are reported in the ORS by the healthcare professional who observes or is made aware of the error. Medication errors include a actual error (any violation of the "5 Rights," as described in #1) and "near misses" (errors that are detected BEFORE they reach the patient.
   - NM receives a confidential monthly report aggregating all medication error data and this data is to be shared with clinical nurses. All nurses should be able to speak to how this information is shared and used by the program of care to improve practice.
   - NPCS collaborates with our pharmacy and medical staff colleagues to identify and improve safe medication practices, and to determine where policies, procedures, and standards of practice can be improved.
   - Pharmacy and Therapeutics Committee (P&T) review quarterly reports of medication error data and trends. Data and trends are used to determine how practice patterns might be improved.
3. What is an Adverse Drug Reaction (ADR)?
   - Any effect of a commercial drug that is NOT intended or expected and that is severe enough to result in the discontinuation of the suspected medication.
   - Any side effect of an experimental drug.
4. What do you do if you suspect an adverse drug reaction?
   - Take care of your patient first.
   - For commercial drugs, the event is reported in the ORS.
   - For experimental drugs, the event is reported to the principle investigator. This information is then forwarded to the FDA, if appropriate.
5. Why are we worried about the security of syringes and needles?
   - There is a risk that inappropriate or unauthorized use of syringes and needles by a patient or visitor may cause harm to a patient or others.
   - Are your syringes and needles secured from public access?
6. Who is responsible for medication refrigerator checks?
   - Medication refrigerators are equipped with electronic temperature monitors. The new temperature monitor is mounted on the outside of the refrigerator and features
     - External digital temperature display, i.e., the current temperature and the recommended range of 2°-8° C.
     - The ability to monitor drug storage temperatures 24/7.
     - An alarm that sounds when the temperature is out of the recommended range.
   - Nurses are responsible for responding when the refrigerator alarm sounds. Directions are posted on the refrigerators that list the actions a nurse will take when the alarm sounds. Are they posted on your refrigerator?? If not, please call Pharmacy to obtain a set of directions.
   - Since it is possible for someone to silence an alarm and then not report the malfunction, nurses should always note the temperature display and that the alarm is turned "ON" as part of their routine use of the refrigerator to be sure it is not registering "out of range."

- Nurses are responsible for monitoring that the refrigerator alarms are always on. If the alarm has been turned off b/c the refrigerator appears to be malfunctioning, nurses are responsible for ensuring that appropriate action has been taken as posted on the front of the refrigerator.
- Pharmacy will check refrigerator monitors monthly to be sure they are working properly, alarms are on, and temperatures are within range. Pharmacy will notify nurse managers if variances are found.

7. What drugs are on the floor stock inventory?
   - The P&T Committee has approved a list of drugs which can be maintained as floor stock. Floor stock drugs are used to meet "**urgent**" patient care needs, ex., acetaminophen for elevated temperatures. For example, in cases where the Pharmacy's normal medication distribution system might cause harm or discomfort to the patient, floor stock drugs are available for immediate use.
   - The floor stock list does NOT include medications needed for "**emergency**" patient care needs, ex., cardiac arrest. ACLS drugs are maintained on the ACLS Cart and brought to the unit at the time a code blue is called.
   - Floor stock does not include "convenience" items which should be dispensed through the standard distribution system.
8. What are high-alert drugs and how do we minimize their associated risks in the Clinical Center?
   - High-alert drugs are those associated with serious patient outcome if misused. Some examples include but are not limited to controlled substances, cytotoxic agents, digoxin, IV potassium, magnesium, and calcium, vasoactives, neuromuscular blockers, some anticoagulants, and insulin.
   - Nursing and Pharmacy have collaborated to develop policies and procedures that would reduce the risk of error and/or mishandling of these high-risk drug categories.
9. Describe the **independent** double check process you use to validate the infusion pump settings on your patient's controlled substance infusion.
   - Two (2) nurses each **separately** review the medical order against the product label and infusion pump settings. This means that each nurse will read the medical order, will read the product label, and will review the pump programming.
10. You have just replaced your patient's fentanyl transdermal patch. Describe how you will dispose of the used patch.
    - When **transdermal** controlled substance units, e.g., fentanyl patches (Duragesic®) are removed from a patient, the unit is cut into several pieces and disposed of in the sharps container. The disposal must be witnessed, cosigned, and documented in the presence of a witness.
    - By way of another example, oral **transmucosal** controlled substance units, e.g., fentanyl citrate (ACTIQ®) also require special handling and disposal.
      - **Partially-used transmuscosal** units are disposed by running the unit under hot water till dissolved. The handle is disposed of in the sharps container.
      - **Opened and unused unused units** can be either run under hot water till dissolved or the medication unit cut off and flushed down the toilet. Do not flush the entire unit, handle, or foil pouch.
      - As with transdermals, the disposal must be witnessed, cosigned, and documented in the presence of a witness.
    - You can find this and other information related information in NPCS Policy: Handling of Controlled Substances **(http://intranet.cc.nih.gov/nursing/contlsub.html)**.
11. Describe steps you would take to waste a morphine sulfate solution obtained from the PYXIS.
    - A nurse can document waste of a controlled substance infusion removed from PYXIS up to 36 hours after removal by taking the following steps: Choose 'Waste' button.
      - Select the patient.
      - Choose 'All Meds' button.
      - Select the patient's infusion medication
      - Choose 'Waste Now' button.

- Enter amount given or amount wasted
- Witness entry required

- The steps described above can be applied to any patient transferred from another nursing unit that originated from another nursing unit.
- Even though the nurse can document the waste up to 36 hours after the removal of the controlled substance infusion from the PYXIS the nurse should document the waste as soon as practicable after the bag has been removed from the patient.

12. When you have a drug-filled syringe, describe the steps you take to ensure you deliver the right drug to the right patient.
    - For patient's safety, the nurse always labels a drug-filled syringes (heparin, saline, steroids, etc.) with the patient's name, date, and the name of the drug.
13. What would you do if you were asked to dispense medication to a patient from a container or package that contained more than one label?
    - You probably don't routinely think about this but you often receive medications that may have the manufacturer's label AND a CC generated label. All labels on the drug product must be congruent with the prescriber's order. If any of the labels do not match, call the Pharmacy to clarify and return the drug product to the Pharmacy, if requested.
    - If the medical order does not match the medication labels, you must seek clarification about the intended dose with the prescriber and take the appropriate action so that the medical order and all drug product labels are congruent.